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ABSTRACT

This monograph is designed to offer a pragmatic or applied focus to the ethical and legal dilemmas facing practitioners in the area of confidentiality and privileged communication. First a glossary of terms is presented. Next the historical perspective of confidentiality is discussed, focusing on from what the counselor's professional duty and responsibility to act derives. The next section explores confidentiality and privileged communication trends from the perspectives of research, professional affiliation, and credentialing. Privacy, informed consent, role duality, negligence, and third-party billing are explored as they relate to confidentiality and privileged communication in the next section. Exceptions to confidentiality are discussed in the following section; these concern the duty to warn and the counselor as witness. Standards applied to diverse settings, such as schools, the armed forces, inpatient environments, etc., are discussed next. Special considerations, such as minor clients, family consultation, etc., are explored in the next section. Privacy and recordkeeping are discussed next. Finally counselor training and confidentiality are discussed. Seven frequently asked questions are stated and answered. Guidelines for practice are listed. A summary and discussion questions are provided. (Contains 72 references.) (ABL)

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"Confidentiality and Privileged Communication"

Gibbs L. Arthur, Jr., MEd
Carl D. Swanson, JD, EdD

Series Editor:
Theodore P. Remley, Jr., JD, PhD

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THE ACA LEGAL SERIES

Volume 6

"CONFIDENTIALITY AND PRIVILEGED COMMUNICATION"

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Preface

This monograph is part of the ACA Legal Series. The subject matter addressed in this volume of the series is particularly important to practicing counselors because of their promise or contract with clients to safeguard information that is shared within the therapeutic relationship. Many previous writers have discussed the significance of both confidentiality and privileged communication in protecting the privacy rights of clients, establishing a framework for trust, and encouraging help seeking by those in need of professional assistance. Additionally, these topics relate to such revered and fundamental precepts in our society as liberty, privacy, autonomy, and self-determination.

The proliferation of counselors and clients, the increasingly diverse populations and contexts in which counselors of all types practice, sociocultural changes in the family and workplace, advances in information-sharing technology, the continued expansion of counselor credentialing, and the evolution of ethical and legal guidelines are some of the factors that make confidentiality and privileged communication a timely topic. The interaction of these complex professional, legal, regulatory, sociocultural, moral, and contextual variables creates a thicket of decisions for the practitioner. The counselor's resolution of each variable stands to influence therapeutic rapport, counseling outcomes, and his or her professional standing and reputation.

The stage is set for ethical misadventures when there are inadequate opportunities in counselor training and continuing education to acquire current information about ethical and legal

guidelines. Moreover, there are scant opportunities to blend theory and personal values, apply these principles in day-to-day clinical situations, and experience how these decisions affect both self and clients. Often students feel the emphasis is upon cramming in knowledge rather than upon experience in applying it.

This monograph, along with others in the ACA Legal Series, is designed to offer a more pragmatic or applied focus to the ethical and legal dilemmas facing practitioners. It offers a distilled compendium and update for students in counseling and allied mental health disciplines, counselor educators, and counseling professionals in a variety of contexts.

We are keenly aware that ethical decision making does not occur in a vacuum but represents an interaction among many factors. Recognizing these complexities, we examine historical perspectives, professional mandates, client privacy, confidentiality exceptions, diverse settings, special considerations, record keeping, and counselor training. We then look at frequently asked questions and provide guidelines for practice and, for the ambitious counselor, suggested readings. This format facilitates use of the monograph by students, counselor educators, and practitioners.

Glossary

Confidentiality: An ethical responsibility and a professional duty that demands that information learned in private interaction with a client not be revealed to others. Professional ethics standards mandate this behavior except when the counselor's commitment to uphold client confidences must be set aside due to special and compelling circumstances or legal mandate.

Competence: A client's capacity to make rational life choices. Incompetence is usually a legal determination, based upon a clinical examination, that a client is unable to make appropriate life decisions.

Informed Consent: The right to be told about the nature and consequences of counseling procedures such that clients are enabled to make informed choices. The application of this concept to confidentiality is discussed more fully in the Client Privacy: Protections and Perils chapter.

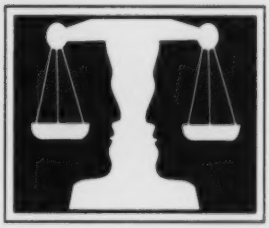
In Loco Parentis: Acting in place of a parent. This is a term that refers to institutions or persons serving as surrogate parents and assuming legal responsibility for a minor's care during the absence, disability, or incapacity of biological parents.

Negligence: A doctrine in case or common law that holds that a counselor who acts in a careless manner is liable for resulting

harm to the client. The professional, under this doctrine, is held to a higher standard of care than the lay person. Negligence can be inferred when an incorrect diagnosis is made, a client's record is released without consent, or records are left lying around and are seen by a third party. Along with incompetence, negligence is one of the most common reasons given for malpractice suits brought against counselors.

Privileged Communication: A legal protection granted by state laws to the clients of specified professionals that information arising from the relationship may not be divulged in certain court proceedings without client consent (sometimes called *waiver*). The specifics of privileged communication statutes vary from state to state.

Professional Disclosure Statement: A written declaration that provides basic information for clients about the counselor's academic and professional background. It may be expanded to include information about confidentiality, philosophy of counseling, fee schedules, and other aspects of treatment a practitioner deems important for clients to consider in their decision to enter into a therapeutic relationship.



Historical Perspective

Confidentiality has been understood historically as an ethical decision made by a professional to not reveal to others what has been learned in private interactions with clients. Confidentiality is a right (with exceptions as noted in the Confidentiality Exceptions chapter) belonging to clients. Privileged communication is a legal privilege, granted by state legislatures, exempting specific professionals (generally those holding a license) from having to disclose certain information in a court of law. Qualifying language, which defines the limits of this privilege, differs from state to state. The privilege belongs to clients and may be waived if they so desire.

The client-counselor interaction constitutes a "special relationship" that mental health professional associations and some state legislatures believe must be kept private to encourage help seeking. Therefore, the public good and clients' welfare are primary considerations in promoting the regulation of helper-helpee communications. Professional ethical codes require that client communications be held in confidence; users of counseling are insisting upon greater privacy considerations; and legislation is increasingly codifying such protections through privileged communication and privacy statutes.

The counselor's professional duty and responsibility to act in an ethical manner can be summarized as emanating from six sources:

1. acts of the United States Congress or state legislatures
2. common or case law
3. administrative law
4. professional association ethical standards
5. personal sociomoral values
6. state credentialing bodies providing licensure, certification, or registration, which promulgate rules for practice and codes of ethics that become incorporated into the law.

For some 50 years the courts have recognized that there is not a complete body of law that explicitly applies to all actions of professionals. Therefore, under the ruliing in *Cherry v. Board of Regents* (1942), a professional's own code of ethics was introduced in a trial to aid the court in rendering a decision. A professional code of ethics, such as the *Ethical Standards* (AACD, 1988), is not formally incorporated into the law, but these standards may serve as quasi-legal guidelines governing professional conduct. All mental health professional codes of ethics have incorporated statements governing confidentiality, which are synopsized in the next chapter.

Historically, privileged communication was extended to only a few relationships, including priest-penitent, attorney-client, and husband-wife. Over the years this protection has been expanded to physician-patient and psychologist-client relationships, and in the past two decades to the relationships of other mental health practitioners such as counselors with their clients.

Over three decades ago, Wigmore (1961) established the following criteria to guide judicial discretion in deciding whether to accord a legal privilege:

- The communications must originate in confidence that they will not be disclosed.
- Confidentiality must be essential to the full and satisfactory maintenance of the relationship.
- The relationship must be fostered because the community desires it.
- Injury inflicted on the relationship as a result of disclosure or communication must be greater than the benefit from proper disposal of litigation.

In its model legislation for state counseling licensure laws, the American Personnel and Guidance Association Commission on

Counselor Licensure (1976) recommended that the counselor-client relationship be afforded the same communication privilege as attorney-client. Herlihy and Sheeley (1987) noted that only 2 states then accorded counselors such a broad privilege, and only 12 states then had any such protective statutes.

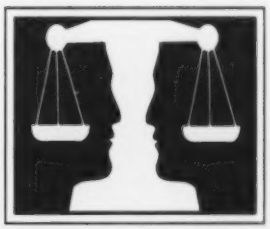
Some states have granted privileged communication status to marriage and family therapists (five were reported by Herlihy and Sheeley, 1987). However, these statutes do not grant privileged communication when multiple clients are present. The literature cites a number of reasons for the exclusion of privilege when more than one client is present, including the dyadic history of privilege protection, a common law tradition that the public has a right to every person's evidence, and another common law principle that the presence of a third party during therapeutic communication constitutes an implied waiver (Hopkins & Anderson, 1990; Watkins, 1989).

The movement toward privileged communication for school counselors has been slow and arduous despite efforts by the American School Counselor Association (ASCA). Only 3 states had passed such legislation by the end of the 1960s, and 16 had done so by 1974. In the decade between 1974 and 1984 only three more states were added to the list.

Counselors need to distinguish between confidentiality and privileged communication. *Confidentiality* is the ethical duty to fulfill a contract or promise to clients that the information revealed during therapy will be protected from unauthorized disclosure. *Privileged communication* is a client's legal right, guaranteed by statute, that confidences originating in a therapeutic relationship will be safeguarded during certain court proceedings. Even if counselor-client relationships are not privileged by state statute, counselors still owe clients the ethical obligation of confidentiality.

Professional guidelines and legal traditions provide a strong mandate for respecting client confidences. The issue of confidentiality is not only an ethical but also a clinical issue. The clinical aspects include maintaining clear boundaries and roles, dealing with triangulation in communication and relationships, and addressing trust-mistrust issues. Ultimately, each counselor's theoretical biases, personal values, and belief system influences the many clinical judgments made, including decisions about confidentiality. These moral choices affect the counselor and client

directly and many others—as well as the profession and the public's perception of counseling—collaterally.



Professional Mandates for Confidentiality

Counselors' ethical choices regarding confidentiality may be influenced by research, professional affiliation, and credentialing. This chapter explores confidentiality and privileged communication trends from these three perspectives.

Research

Much research regarding confidentiality and privileged communication has been historical and descriptive in nature. Articles offering empirical evidence regarding confidentiality have relied heavily upon survey methodology in examining client and mental health professionals' perceptions about confidentiality, gender variables, the effects of various confidentiality conditions, and the impact of privilege laws. Many studies utilized college students as subjects. Conclusions gleaned from research relevant to counselors' ethical behavior regarding confidentiality include the following:

- The general public, clients, and mental health professionals appear to share an expectation of privacy in the counseling relationship; clients prefer to know in advance about confidentiality limitations; the degree of confidentiality as-

surance seems neither to enhance nor diminish later client disclosiveness; and findings to date are mixed and inconclusive about whether client knowledge of confidentiality limitations at the beginning of counseling inhibits subsequent disclosiveness (Baird & Rupert, 1987; Haut & Muehleman, 1986; McGuire, Graves, & Blau, 1985; McGuire, Toal, & Blau, 1985; Miller & Thelen, 1986; Muehleman, Pickens, & Robinson, 1985; Rubanowitz, 1987).

- Minors at about the age of 15 appear to possess the capacity to understand and exercise a number of rights, including confidentiality (Belter & Grosso, 1984).
- The influence of privilege laws upon client disclosiveness may relate to how well clients understand these protections and how relevant they are to client circumstances (Taube & Elwork, 1990).
- More experienced psychotherapists tend to be more conservative regarding therapist-client confidentiality (Conte, Plutchik, Picard, & Karasu, 1989).

Professional Affiliation

McGowan (1991) noted that many counselors may be surprised to learn that confidentiality is not protected by law but is instead governed almost completely by ethical guidelines advanced by professional associations. Further, it is the *breach* of confidentiality rather than the *act* of confidentiality that professional standards protect. The transgression of confidentiality has also become a matter of law through court decisions and may thus be considered a part of our common law. Clients usually have the expectation of confidentiality because of ethical standards rather than legal requirements. When counselors violate the privacy expectations that clients bring to professional relationships, counselors can be held legally accountable.

Professional associations such as the American Counseling Association and its various divisions, the American Psychological Association (APA), the National Association of Social Workers (NASW), the American Association for Marriage and Family Therapy (AAMFT), the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), and others have developed standards to guide the ethical conduct of their members. Statements of the associations are quite similar in the area of con-

fidentiality (only general portions of confidentiality standards are cited here; special considerations are addressed in a later chapter):

- Members make provisions for maintaining confidentiality in the storage and disposal of records and follow an established record retention and disposition policy. The counseling relationship and information resulting therefrom [must] be kept confidential; consistent with the obligations of the member as a professional person. (AACD, 1988, section B.2)
- Psychologists have a primary obligation to respect the confidentiality of information obtained from persons in the course of their work as psychologists. They reveal such information to others only with the consent of the person or the person's legal representative, except in those unusual circumstances in which not to do so would result in clear danger to the person or to others. Where appropriate, psychologists inform their clients of the legal limits of confidentiality. (APA, 1990, Principle 5)
- The social worker should respect the privacy of clients and hold in confidence all information obtained in the course of professional service. (NASW, 1990)
- The alcoholism and drug abuse counselor should embrace, as a primary obligation, the duty of protecting the privacy of clients and should not disclose confidential information acquired in teaching, practice, or investigation. (NAADAC, 1987)
- The overriding principle is that marriage and family therapists respect the confidences of their clients. AAMFT's code of ethical principles recognizes the unique problems associated with having more than one client. (AAMFT, 1991, no. 2)

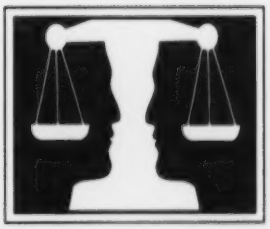
Credentialing

The expansion of counselor credentialing nationally and within individual states imposes legal and ethical duties upon counselors relative to confidentiality and privileged communication. Over 32,000 counselors are certified through a variety of national organizations such as the National Board for Certified Coun-

selors, the Academy of Clinical Mental Health Counselors (ACMHC), and the Commission on Rehabilitation Counselor Certification (CRCC). Many of these certifications require that counselors maintain confidentiality.

Bradley (1991) indicated that 34 states license, certify, register, or otherwise credential over 46,000 family, marriage, child, and individual counselors. Many of these states have promulgated standards of practice that include statements about confidentiality.

California and Texas, which together license nearly half of all counselors nationally (about 48% according to Bradley, 1991), both address confidentiality in legal statutes (privileged communication). These statutes are then cross-referenced in the rules and regulations governing counselors (Texas State Board of Examiners of Professional Counselors, 1991; Kathleen Callanan, California Board of Behavioral Science Examiners, personal communication, February 25, 1992). Licensed counselors in California and Texas have a legal mandate to maintain confidentiality except as allowed by statute (both state codes allow for a number of exceptions). The presence or absence of a privileged communication statute protecting counselor-client relationships does not in any way diminish a counselor's general ethical obligation to keep client information confidential.



Client Privacy: Protections and Perils

Counselor decisions regarding confidentiality may often be influenced by corollary considerations and obligations. In this chapter privacy, informed consent, role duality, negligence, and third-party billing are explored as they relate to confidentiality and privileged communication. An additional issue, the counselor's duty to warn, is addressed in the next chapter's discussion of confidentiality exceptions.

Privacy

Individual rights protecting private matters from unreasonable intrusions are a democratic tradition evidenced in both common and constitutional law. *Privacy* refers to an individual's freedom to make choices about the dissemination of personal information and protection from undue interference into private affairs by parties without a legitimate need or privilege to know this material (Hopkins & Anderson, 1990; Stadler, 1990). The foreword to the section on the counseling relationship in the *Ethical Standards* (AACD, 1988, section B) states that the counselor "must recognize the need for client freedom of choice." In situations in which this is not possible, the counselor is obligated to advise clients about restrictions that may compromise their freedom of choice.

Privacy protection measures have been recognized increasingly by both federal and state statutory law. One of the better known statutes is the 1974 Family Education Rights and Privacy Act, better known as the Buckley Amendment. This federal statute protects the privacy of any records kept in an educational institution by any employee.

Privacy protection acts were passed to protect the individual whose right to due process and other legal protections are endangered by the misuse of personal information systems. Language contained in the Virginia code (Privacy Protection Act of 1976) says that ". . . an individual's privacy is directly affected by the extensive collection, maintenance, use, and dissemination of personal information" (§ 2.1-379.2.). All persons included in information systems have the right to inspect all personal information. In most states, if a record to be inspected is medical or psychological in nature, the individual may have to designate a physician or psychologist to obtain the record. (It is hoped that statutes will expand this access to other licensed professionals.)

Counselors, particularly those employed in governmental or quasi-governmental agencies, are well advised to ascertain the existence of privacy laws in their states and, if applicable, the scope and requirements thereof. Such provisions impose additional legal duties upon counselors to protect client privacy. With this "opening" of records, the professional must see that there is no information contained therein that may be defamatory or in other ways harmful to the subject of the record.

Informed Consent

The concept of informed consent is predicated upon clients' freedom of choice to make intelligent decisions about matters that will affect their lives. This principle has been applied in a variety of medical, legal, educational, and other contexts. *Informed consent*, as it relates to confidentiality, refers to the client's right to understand the limits of confidentiality at the commencement of the counseling relationship as well as the risks and benefits associated with authorizing a particular disclosure of private counseling information. The *Ethical Standards* contain the following statement:

> The member must inform the client of the purposes, goals, techniques, rules of procedure, and limitations that may affect the relationship at or before the time that the counseling relationship is entered. When working with minors or persons who are unable to give consent, the member protects the clients' best interests. (AACD, 1988, section B.8)

Bray, Shepherd, and Hays (1985) identified three legal elements needed to establish informed consent: capacity, comprehension, and voluntariness. *Capacity* refers to the client's ability to make rational life choices. *Comprehension* requires that clients be given information on risks and benefits in clear language they can understand. Counselors should verify that adequate client comprehension of this information has occurred. *Voluntariness* means that the client's assent is given freely. Further, the consenting individual must be mentally competent and legally able to provide such permission.

Competence to grant consent is usually assumed unless there is a basis to believe otherwise. Incompetence at the time of consent, such as when authorizing the release of confidential information, may render permission invalid. Assessing psychological competence to give consent requires specialized training and experience. If there is a question about a client's competency due to mental retardation, mental illness, or physical infirmity and the counselor lacks evaluation skills, consultation with or referral to other qualified professionals is indicated.

One recommended approach to informing consumers is providing clients with a professional disclosure statement that outlines the professional's background and includes such counseling procedures as a fee schedule and a cancellation policy. Confidentiality and its major exceptions can be addressed in such consumer information. Some counselors may elect to chronicle their professional background in a disclosure statement and cover counseling procedures in a separate document. An outline and sample for constructing a consumer disclosure document appeared in a paper by Thomas Nagy titled "The Well-Educated Consumer: Informing Clients and Protecting Providers" that was presented at the February 1988 California Psychological Association Annual Convention (cited in Fisher, 1991).

Role Duality

Dual role relationships occur when one individual is participating simultaneously or sequentially in role categories that compete or conflict with one another (Kitchener, 1988). Such conflicts serve to compromise the counselor's objectivity, blur role boundaries important to the therapeutic relationship, and jeopardize confidentiality. Many dual relationship possibilities exist for those in counseling roles, including being supervisors, faculty advisers, researchers, business associates, or relatives; allowing clients to barter goods or services in exchange for counseling; and becoming involved in personal intimacies (AACD, 1988; Kitchener & Harding, 1990).

The potential counselor-supervisor role conflict has received considerable attention in the professional literature and ethical standards. The *Ethical Standards* state that:

> When the member has other relationships, particularly of an administrative, supervisory, and/or evaluative nature with an individual seeking counseling services, the member must not serve as the counselor but should refer the individual to another professional. Only in instances where such an alternative is not available and where the individual's situation warrants counseling intervention should the member enter into and/or maintain a counseling relationship. (AACD, 1988)

The *Ethical Standards* further provide that any relationship, such as with close friends or relatives, in which the counselor's objectivity or professional judgment may be impaired should be avoided. Kitchener and Harding (1990) discussed the conflicts associated with the supervisor-counselor and client-supervisee combination. A supervisor has dual responsibilities to the supervisee, the work setting, and the supervisee's client. Confidentiality is not necessarily accorded the supervisory relationship. The counselor role, by contrast, requires that the primary obligation is to the client to whom a duty of confidentiality is owed.

The counselor must avoid situations in which other roles will compromise client confidentiality, create an imbalance of power in the relationship that restricts client autonomy, impair therapeutic neutrality (objectivity), or interfere with professional judgment.

Negligence

Careless handling of records or a "slip of the tongue" can well constitute (actionable) negligence because confidentiality can be breached. This contract by the counselor to keep private what a client has divulged is broken, even though no intent to do so is present, when information is advertently released. For example, records left open and unattended in an office may be seen by a third party. Information that has not been secured within a computer system may be divulged. Even a statement to a person authorized to access information can be overheard. Constant awareness of the need for total confidentiality can avert needless negligent violations of the confidential relationship.

Third-Party Billing

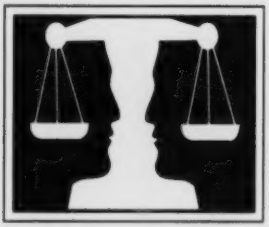
Many counselors face ethical dilemmas in submitting insurance claims to obtain client reimbursement for their professional services. Some counselors believe that making diagnoses and submitting other treatment information required for third-party billing subjects clients to stigma, potential discrimination, and invasion of privacy because the service provider has little or no control over how this information is handled once it is transmitted to the insurer. Others view third-party billing as a professional duty and service, arguing that without this resource some clients could not afford to seek help.

Sederer (1987) and Clamar (1985) discussed confidentiality concerns related to the increasingly common practice known as peer review (PR). PR is designed to determine whether the treatment provided is "medically necessary" and appropriate and may occur before, during, or subsequent (prospective, concurrent, or retrospective review) to the delivery of professional services. Recently, the rapid growth of managed mental health care, which often involves the submittal of more extensive treatment information, has apparently refueled concerns about client privacy issues.

Often a client's signature may appear on claim forms or insurance enrollment documents containing a general authorization to release medical information. This, however, does not discharge the counselor's ethical and legal duty to insure that informed consent criteria have been satisfied. Counselors are

obliged to review the scope and extent of information requested with clients in advance of releasing it. When extensive information is requested that could have far-reaching implications for the client's employment status or security clearance, for example, counselors must make reasonable efforts to advise clients about the potential positive and negative consequences that might arise from granting disclosure. A breach of the counselor's duty to inform clients adequately may result in a malpractice suit or an ethical complaint against the practitioner.

From a legal perspective, insurance companies that pay for mental health treatment are entitled to information regarding the services provided either by state statute, the benefits contract, or specific client authorization. If this information is not provided, insurers may withhold reimbursement until it is received. Privacy belongs to clients. They may choose whether to waive this right, and if a client elects to do so, the counselor should then cooperate in disclosing information to third parties as requested. If a counselor refuses to release requested case material authorized by client waiver, which then results in the loss of third-party reimbursement for services rendered, the client may have a legal cause of action against the counselor.



Confidentiality Exceptions

Regardless of legal privilege, professionals are ethically obliged to respect confidentiality of clients. An implied contract or promise always exists; but it is never absolute and exceptions can occur (Bissell & Royce, 1992). Such exceptions include the following:

1. The client is a danger to self or others. The law places physical safety above considerations of confidentiality or the right of privacy. Protection of the person takes precedence and includes the duty to warn.
2. The client requests the release of information. Privacy belongs to the client and may be waived. The counselor should release information as requested by the client.
3. A court orders release of information. The responsibility under the law for the counselor to maintain confidentiality is overriden when the court determines that the information is needed to serve the cause of justice.
4. The counselor is receiving systematic clinical supervision. The client gives up the right to confidentiality when it is known that session material will be used during supervision.
5. Clerical assistants process information and papers relating to the client. The client should be informed that office per-

sonnel will have access to the records for routine matters such as billing and record keeping.

6. Legal and clinical consultation are needed. Again, the client should be informed of the (ethical) right of the counselor to obtain other professional opinions about progress and the name(s) of those used as consultant(s).
7. Clients raise the issue of their mental health in a legal proceeding. In a custody suit, for example, parents introduce their mental condition into the suit, whereupon they authorize release of the counselor's records.
8. A third party is present in the room. Clients are (presumably) aware a person other than the counselor is present and therefore waive their right of privacy in permitting the third person to be present.
9. Clients are below the age of 18. Parents or guardians have the legal right to communication between the minor and the counselor. (Possible exceptions are given in the Special Considerations chapter.)
10. Intra-agency or institutional sharing of information is part of the treatment process. Otherwise confidential material may be shared among professional staff when it is in the interest of the client to do so. However, the client must be aware that this is being done.
11. Sharing of information is required within a penal system. Information obtained from prisoners that may otherwise be considered confidential may be shared within the system in the interest of the operation of the system and disposition of the case.
12. The client's purpose in disclosing information was to seek advice in the furtherance of a crime or fraud. The obligation here changes from one of maintaining confidentiality to one of protecting society from further criminal activity.
13. The counselor has reason to suspect child abuse. All states now legally require the reporting of suspected abuse.

Another exception may apply to situations in which there is a court-ordered mental health evaluation or in which the counselor has served as an evaluator in determining that a client requires involuntary hospitalization.

In addition to the preceding guidelines, certain state laws may permit the transmission of confidentiality information without

client consent (a) between public or quasi-public community mental health clinics and public psychiatric facilities; (b) to guardians ad litem or other special court-appointed advocates for children or incapacitated adults (depending upon the statute, disclosure may occur with or without a specific court order to that effect); (c) to noncustodial parents who are deemed to have a right to medical information; (d) to qualified service organizations that provide contractual services such as bill collection, lab work, legal services, accounting, consultation, and peer reviews (Piazza & Yeager, 1990); and (e) when the information relates to the care, treatment, classification, or release of prisoners.

Duty to Warn

In the interest of the public welfare and safety, professionals have long been released from confidentiality when they determined that a client presented a serious danger to self or another. The 1976 landmark case of *Tarasoff v. Regents* in California established that the protective privilege (of the therapist) ended where the public peril began. The counselor now must make an ethical and clinical decision to answer the question, "Is it likely that my client may harm another or self?" The *Ethical Standards* (AACD, 1988) support the counselor taking action to inform appropriate authorities when "the client's condition indicates there is a clear and imminent danger to the client or others." Consultation with other professionals is encouraged.

The *Tarasoff* standard has been expanded to include protection of unidentifiable victims, even the general public, as well as potential targets of violence specified by the client (Pietrofesa, Pietrofesa, & Pietrofesa, 1990). In other words, the counselor has a legal duty to take reasonable steps to protect third parties from violent clients, such as securing psychiatric hospitalization on a voluntary or involuntary basis, depending upon the client's condition and situation. It is just as important to protect the client from self-harm. Information may have to be released to secure hospitalization when no other viable alternatives exist and suicide seems likely. Involuntary commitment is, of course, a last resort.

What if the client confesses to selling dangerous and illegal drugs on high school grounds? The best policy today is to take steps to protect high school pupils from drugs that could be fatal.

Of course, this is done after the counselor has exhausted other possible avenues with the client to rectify the situation.

If the action confided by the client were simply illegal, it could be argued that revealing this information (about shoplifting, for example) is neither ethical nor constitutes a duty under the law. Counselors are under no legal obligation to report a client's past or ongoing criminal activity. Of course, criminal behavior that has harmed or threatens harm to others is an exception.

What if a client is a practicing alcohol or other drug abuser and drives in a condition that is unsafe? When behind the wheel of an automobile and intoxicated, such a client can be just as lethal as a client with a loaded pistol. It is suggested that the counselor does have a duty here to intervene when nothing else will dissuade this client from driving under the influence.

Pietrofesa et al. (1990) and the *Tarasoff* opinion have given helpful guidelines to the counselor who has assessed a client and situation as being dangerous to afford clients maximum privacy protection:

- As in all other situations, discuss the issue fully and openly with clients.
- Inform clients of the counselor's legal responsibility to warn others.
- Inform your supervisor of the potentially dangerous situation. If there is no supervisor, consult with another professional.
- Notify the person who might be responsible for the client or contact the police.
- Notify the intended victim.
- Explore other options, which may include commitment to an appropriate psychiatric facility.

The counselor is further advised, consistent with informed consent guidelines, to let clients know at the start of the therapeutic relationship about those areas in which there is a duty to breach confidentiality. Proof that clients have been informed may be accomplished by documenting such advisement in the counseling record or by providing clients with a disclosure or consumer information statement, receipt of which is noted in the record.

It is clear that when there is a likelihood of self-harm, confidentiality must be breached to protect the person. An October 1991 decision by the Maryland Court of Appeals (*Eisel v. Board of Education*) seemingly expanded this duty for school counselors. Two Maryland school counselors did not inform a parent of suicidal statements made by his child to fellow students. The appellate court held that the counselors may have breached a common law duty to intervene to prevent the child's threatened suicide. The protection of life is the overriding concern.

The Counselor as a Witness

Counselors often discuss matters that are later subject to legal proceedings for which they may be called as witnesses. Even though confidentiality belongs to the client and, in general, only the client can authorize a waiver, there are occasions when there is an implied waiver by the party initiating legal action. Clients should therefore be aware that actions they take may constitute a waiver of confidentiality.

Remley (1991) cited a number of instances where clients become involved in the legal system, including divorce, support, and custody disputes; personal injury suits; criminal defendants; abuse cases; job-related controversies (including sexual harassment); character defamation litigation; and breach or contract actions. Counselors may also be the subject of regulatory actions.

When the counselor appears as a witness in court, the confidentiality of client-shared information may hinge upon a number of factors: (a) whether client waiver has been granted (testimony may be compelled even if the client does not consent); (b) the extent of privilege protection accorded by the governing state statute; (c) whether the counselor, absent a client waiver, asserts counselor-client privilege (requests that the judge honor the privacy of certain or all information); (d) the trial judge's discretion regarding the relevance of the counselor's testimony as well as rulings regarding legal motions; and (e) legal precedents applicable to the issue(s) under review.

Counselors in court are not advocates; that is the attorney's role. The counselor is typically a neutral witness under oath to supply such truthful facts as may be requested. Willful omission or alteration of evidence may subject the counselor to criminal charges such as perjury or tampering with evidence. The coun-

selor may be held in contempt of court for refusing to answer questions. However, the counselor has an ethical responsibility to ask that the presiding judge not force his or her testimony regarding confidential or privileged counselor-client communication. A determination about whether to require the counselor's confidential testimony is then at the judge's discretion.

Counselors should avoid discussing details of a court case casually because this information may be used in cross- examination. The counselor should contact the attorney most likely to be helped by his or her testimony in advance of the trial to review anticipated questions. If the court action is against the counselor or contact with other involved legal counsel does not prove satisfactory, the counselor should consult an attorney. (See Remley, 1991, in this series for guidelines on choosing a lawyer.)

Standards Applied to Diverse Settings

The work setting of the counselor may play a significant role in determining legal responsibilities. Statutory, administrative, and institutional regulations may determine the course of action the professional must take, even though it might appear to be contrary to established case law or ethical standards. The counselor must be fully aware of rules governing practice within a particular agency. The counselor may, at times, have to choose between accepting rules of an agency or terminating employment. Examples of settings in which there are special legal and ethical considerations include schools, the armed forces, inpatient environments, outpatient situations, prisons, chemical dependency treatment facilities, and small communities or campuses.

Schools

School counselors may find themselves in confidentiality binds because of school policy, the advice of school board attorneys, and administrative directives. A school serves as a surrogate parent, and this in loco parentis role further muddles ethical-legal decision making for school counselors. The area of confidentiality is one with many conflicting demands for information coming from parents, teachers, and administrators. In the midst of often confusing messages from parents, administrators,

policies, legal opinions, and ethical standards, school counselors must remain focused upon the pupil-client's best interests.

School counselors should keep abreast of evolving ethical and legal developments relevant to their setting. This will enable them to influence policies and other decisions where possible and appropriate. Close contact with the American School Counselor Association and state school counselor associations can be useful. When doubts arise about a course of action contact, through channels, the school board attorney or a personal attorney. Keeping up with such journals as *The School Counselor* and *Elementary School Guidance and Counseling* is most helpful. (See also *Counseling Minor Clients*, by Mark Salo and Stephen Shumate, in ACA's Legal Series.)

Armed Forces

Does the military mental health practitioner have a dual duty to the client and the institution? Questions have been raised about the informed consent and confidentiality protections accorded service persons who seek mental health treatment. Some have commented that military service engenders paternalism. Hanson (1985) contrasted confidentiality and privileged communication standards for the military, a university health system, and a psychiatric hospital. He concluded that the law governing military psychiatrists imposed confidentiality limitations and failed to recognize the physician-patient privilege. A subsequent article (Howe, 1989) contended that the military physician's obligation to the armed forces may conflict with or be outweighed by the duty owed to patients.

Military professional persons usually acquire rank more rapidly by virtue of their specialized training and thus, to a certain degree, become part of the military establishment. Because of rank, military mental health professionals may act in a supervisory or administrative capacity relative to clients. Additionally, they may feel pressure from higher ranking personnel to discuss a client's mental status, particularly if the client's current functioning might compromise military morale, objectives, or national security. Traditionally, the military establishment has taken a dim view of behavior it believes could disrupt morale, such as homosexuality, or be dangerous, as with drug abuse. Releasing certain confidential mental health information about

clients can subject military personnel to potential discrimination, ridicule, forced discharge, loss of promotional opportunities, and other negative consequences. Military counselors may face competing interests other than the client's welfare and privacy that will demand clinical judgment.

There are many questions without easy answers that the profession, and particularly military mental health practitioners, must address. The potential exists for confidentiality boundaries to become so permeable that service persons are discouraged from seeking treatment for mental health problems and are left to suffer in silence, which may also affect performance outcomes. Therefore, military personnel should be told about confidentiality limitations, and this issue should be periodically addressed as part of treatment. Counselors should discuss the implications of confidentiality waivers with clients so their choices will be informed.

Inpatient Environments

The inpatient environment is one in which a number of usually unacquainted persons experiencing significant coping problems are thrust together. In this hospital-type setting they eat, sleep, and work on their problems together for 24 hours a day. (Counselors, generally, refer to these persons as clients.)

Aspects of inpatient situations that may have an impact on generally accepted confidentiality guidelines include the following:

- **Therapeutic milieu or therapeutic community.** Many inpatient programs rely upon the therapeutic milieu or therapeutic community as part of treatment. Here clients and other elements of the living environment are utilized as part of treatment. There are times counselors may be faced with questions about how much information to share about clients in a group context when the information has not been introduced previously by clients themselves. Further, clients may feel pressure from their inpatient peers to share information of a personal nature.
- **Multidisciplinary teams.** Multidisciplinary teams involve professionals from various disciplines who meet and share information about clients for the purpose of assessment, planning, and treatment coordination. Team consult-

ation is fully discussed in the section on nondyadic situations in the Special Considerations chapter.

- **Utilization reviews.** There may be both inhospital and third-party utilization reviews regarding the need for continued treatment. Certain diagnostic and treatment information is needed (by insurers, for example) to make such decisions. This process sometimes occurs absent the client's knowledge or consent.
- **Increased likelihood of child abuse revelations.** Once placed in a protective, supportive treatment environment, clients are sometimes more apt to reveal child abuse that has occurred in their lives—and that professionals are generally required to report. These revelations can pose complications for both clients and treating professionals, including court involvement, extrafamilial posthospital placement, anger, and denial from family members.
- **Federal confidentiality laws for substance abuse treatment facilities.** Federal regulations govern confidentiality in alcohol and other drug abuse treatment facilities receiving federal funds. These laws are generally stricter than normal guidelines for maintaining confidentiality in other inpatient treatment centers. Extensive guidelines for valid consent forms are spelled out by the Department of Health and Human Services (cited in Piazza & Yeager, 1990). Failure to follow federal guidelines can result in the loss of federal funds but is not grounds for finding a counselor negligent or guilty of a crime.
- ***Tarasoff*-related issues.** The *Tarasoff* principle (see the discussion in the Confidentiality Exceptions chapter) has been extended in inpatient settings. Clients are entitled to certain information about their peers when their safety is an issue.

It is important in the inpatient setting for counselors to let their clients know of these possible exceptions to traditional guidelines for maintaining confidentiality. Confidentiality limitations should be explicitly spelled out for clients when consent forms are signed. Counselors must be aware of all policies as well as accrediting or licensure standards applicable to the setting that address confidentiality. A failure to follow such guidelines could be used to show that the counselor breached a duty to the client in a malpractice suit.

Outpatient Situations

Some of the issues facing inpatient counselors are also present in the outpatient setting. Factors influencing confidentiality may include:

- recent insurance (reimbursement) trends favoring outpatient treatment with periodic checks on progress
- existence of state laws allowing commitments to structured outpatient care that subjects clients to legal scrutiny
- agency policies and job descriptions
- state privileged communication laws
- reviews by managed care organizations including peer reviews.

(For a discussion of issues related to privilege laws and third-party insurance, see the section on third-party billing in the Client Privacy: Protections and Perils chapter.)

Reimbursement by third-party insurers for inpatient treatment has declined markedly in favor of other interventions considered more cost effective, i.e., more concentrated outpatient services. Precertification and increasingly intensive utilization review for inpatient care has resulted in some clients being refused admission even though counselors believe them to be a danger to self or another. Others in similar circumstances are being discharged from hospitals more and more quickly. This has translated into an increase in difficult and risky situations being handled on an outpatient basis and a corresponding increase in the degree of responsibility and legal liability the counselor must assume.

Some states have enacted outpatient commitment laws for mentally ill persons that force noncompliant and reluctant clients to seek treatment. Miller (1988) overviewed the current status of such laws and their ethical implications. Even though committed persons have been adjudged mentally ill and ordered to participate in treatment, they are rarely declared legally incompetent. This presents a real dilemma for the counselor in deciding what to do if a client so ordered fails to keep an appointment. Some counselors complain that outpatient commitment laws lack any real enforcement provisions for those who do not comply. Does the counselor immediately report a failed

appointment to the committing authority or instead attempt further follow-up by phone, letter, or through outreach teams (if available) that will make home visits? We promote always giving the client the benefit of any doubt and encourage counselors to make all reasonable efforts to contact the client before notifying authorities, as long as safety is not a factor.

For counselors employed in agency settings, policy and job descriptions may affect their ethical decision making. Counselors who function outside the parameters of their job descriptions or agency policy risk the possibility of being held individually accountable if a client sues for malpractice. They could also face disciplinary action by the employer.

Current trends accent the importance of counselors informing clients about confidentiality limitations at the outset of treatment. Further, it has become all the more critical for practicing counselors to understand confidentiality protections and exceptions, including when they should consider breaching client confidence (i.e., duty to warn). Knowing and following job descriptions and policies will aid counselors facing malpractice allegations, although this does not provide absolute protection from litigation.

Prisons

States are apparently moving to a freer exchange of information about prisoners than possible if normal ethical and legal guidelines governing confidentiality were observed. A 1991 amendment to the Code of Virginia (Institute of Law, Psychiatry, & Public Policy, 1991) virtually opens prison records, and not just within the Department of Corrections. Access is provided to members of the parole board as well as medical and mental health facilities, including community service boards (quasi-public community mental health centers). Records may be released for use in planning and supervising medical and mental health care upon the offender's release from a correctional facility. The only exempt records are AIDS test results and those relating to substance abuse that are subject to federal law. Due to this wide dissemination, greater care is needed in keeping prison records, and counselors working with public offenders should fully disclose these confidentiality limitations.

Chemical Dependency Treatment Facilities

Due to action by the federal government, more stringent rules regarding confidentiality apply to substance abuse treatment facilities. The clearest example of this increased diligence is that the names of clients in treatment may not be released without their express consent. Generally, hospitals may release the names of patients, but because admission to a substance abuse treatment facility constitutes a diagnosis, the fact of admission itself may not be divulged. Requirements for the actual release of information to other treatment facilities are also stricter. The U.S. Department of Health and Human Services (1987) regulations must serve as the guide for allowable action within these specialized treatment programs.

Other factors must also be considered. Twelve-step groups, such as Alcoholics Anonymous (AA), are an integral part of a great majority of addiction treatment center programs. These groups are independent of the facility, often being led by local AA members. However, recovering counselors who are staff members attend these meetings. As these groups stress anonymity as integral to recovery, counselors must not reveal any information coming from them or in any way let it become a part of a client's record. Other staff members should not be told what was said in these meetings even if doing so could be therapeutically beneficial.

The issue of the client's competence to sign a release-of-information form also arises. Many enter these facilities in a toxic state and are unable to think clearly or rationally. A client's ability to give informed consent may still be impaired even subsequent to acute detoxification, especially in complicated withdrawal cases.

When practicing in these centers, counselors should exercise extra care and make sure they are familiar with federal guidelines governing confidentiality. Counselors should also exercise care in releasing information to insurers in order to secure reimbursement for the patient's bills. Further, employers sometimes request information about their employees, and counselors should ask how much the employer might learn. Remember that a client in this setting, under the influence of one or more chemicals, might be willing to sign or say anything! This is not informed consent.

Small Communities or Campuses

Special problems of confidentiality arise in small (usually) rural communities and on small college or school campuses. The fact that a person is receiving counseling becomes known very quickly. Because statements are often imputed to counselors when they have only said, for example, "Yes, she is a client," the counselor is advised not even to say Yes or No as to whether a person is a client but rather to affirm that no information whatsoever can be given about those receiving services. It is very important for the counselor to have the reputation in the community or on the campus of being very discreet and for saying nothing about clients at any time.

Impulsive, acting-out clients are apt to present particular problems (Phillips & Baker, 1983) with managing confidentiality because the externalizing nature of their problems is more clearly visible to others. In these cases and others as well, it is quite likely that certain client information will seep out in the community. This sometimes happens despite the best efforts of persons involved in the therapeutic relationship. Some clients feel obliged to provide private information to those who inquire, and there is nothing to constrain them from doing so because the right to privacy belongs to them. The counselor must remain on guard not to confirm, deny, or even correct information about clients who may be the subject of curious inquiries. Handling these third-party inquiries diplomatically takes skill on the part of the counselor. In all these diverse settings the counselor must be fully aware of principles peculiar to each area and how to handle each situation as it arises in order to avoid legal liability.

Special Considerations

Counselors may encounter particular difficulties and dilemmas in maintaining and ensuring confidentiality and privileged communication in relation to AIDS, minor clients, nondyadic situations, marriage and family counseling, family consultation, multiculturalism, gerocounseling, and sex offender counseling. Each of these areas and their special considerations are discussed in this chapter.

Acquired Immune Deficiency Syndrome (AIDS)

Serious ethical dilemmas result today with the advent of the AIDS epidemic. Recently a counselor reported the case of a client who was a professional man admittedly carrying the AIDS virus. This client confessed having unsafe or unprotected sex frequently with both his wife and an extramarital partner. The client could not be persuaded to inform either partner or to take reasonable precautions against infecting either. The counselor was faced with the question of whether or not to inform both these persons. This case was presented recently for discussion at a workshop for professionals. They were unanimous on informing the wife; but only about 50% favored informing the mistress. Among these professionals there was apparently no general problem in warning presumed victims about the prospect of HIV infection; but on how far to extend their breach of con-

fidentiality beyond the most immediate risk—the wife—there were differences.

The case is an illustration of the the counselor's duty to warn a third party who might be harmed, which is an exception to confidentiality pursuant to the *Tarasoff* standard (see the discussion on *Tarasoff* in the Confidentiality Exceptions chapter). The counselor's legal and ethical responsibilities extend to both sexual partners in this scenario, both of whom could sue the counselor for failing to caution them about the potential health danger.

Cohen (1990) suggested a model rule concerning the limits of confidentiality in cases in which clients have a contagious and fatal disease. The following recommendations regarding confidentiality management with AIDS clients represents a blend of our thoughts with those offered by Cohen:

- Inform the client about confidentiality limits in the first session.
- Inquire about the medical evidence regarding the disease even though direct knowledge is lacking.
- Assess the client's degree of risk to others based upon current behavior and sexual practices.
- Offer education and support to clients and encourage clients to share information about their AIDS infection with those having a need to know if the clients have not already done so.
- Discuss with the client the appropriateness of referral to an AIDS support group.
- Address the denial of the illness that is part and parcel of the grief process and may also be associated with other underlying psychological factors.
- With client consent, contact the involved physician to request his or her assistance in modifying the sexual behavior of AIDS clients who decline to notify their sexual partner(s) about the disease.
- If other earlier steps fail in getting the AIDS client to notify sexual partners, consult with at least two colleagues with expertise in counseling ethics and document the results of such consultations. Erickson (1990) suggested getting a consensus opinion from three out of four professionals.

- If a consensus to breach confidentiality is reached among those with whom consultation is sought, advise the client of what actions will be taken and proceed to make a report to public health, other appropriate authorities, or potential victims.

Due to the fatal nature of AIDS, it appears that a clear and imminent danger to another is present when unprotected sexual contact occurs involving the exchange of bodily fluids. Pursuant to the *Ethical Standards* (AACD, 1988) the member should take personal action to notify potential victims and inform responsible authorities if the client fails or refuses to do so after reasonable opportunities. For the counselor to do any less is potentially as harmful to the person (or society) as when the counselor did not warn the person that her ex-lover was headed to her home with a loaded rifle.

Minor Clients

Do the same standards of confidentiality apply to a minor (under age 18) as to adults? Remley (1985) contended that even the youngest child in counseling is entitled to some privacy. He noted that the counselor is under no legal obligation to inform parents when their children discuss birth control, abortion, or pregnancy. (Some states have since enacted more restrictive laws relating to obtaining permission for or counseling about abortions.) Remley suggested the following guidelines:

- Inform the child before disclosing information to others.
- Attempt to involve the child in the decision making.
- Keep the child informed of decisions as they are made.

What has become known as informed forced consent may best be applied to the release of information obtained from the child. Hereunder, the child is informed of the information that will be revealed, but it is done as a result of the best clinical judgment of the counselor. This posture is consistent with the *Ethical Standards* (AACD, 1988), which provide that "When working with minors or persons who are unable to give consent, the member protects these clients' best interests" (section B.8).

Apparently, little damage is done to the counselor-client relationship when the client is a young child if certain elements of the counseling session are shared with the family or significant persons. The counselor must exercise clinical judgment whenever information is shared. The central question to be answered in making such a decision is whether the release is really therapeutic and in the best interests of the child.

Hendrix (1991), citing a Supreme Court decision, concluded that informed forced consent ceased to apply with respect to minors over age 14 who objected to their involuntary psychiatric hospitalizations. Some states, Pennsylvania and Virginia to mention two, have enacted laws regarding the involuntary psychiatric hospitalization of minors that provide added due process safeguards. These statutes vary but may allow minors, age 14 and older generally, the right to admit or withdraw themselves voluntarily from psychiatric facilities and to object to such hospitalization by parents or others in a hearing. It is speculated that the implication of the case and statutory laws is that minors ages 14 and over have rights to self-determination and consent that parallel those of adults. Legally, if such minors can seek or refuse treatment, they may also be considered competent to decide what, if any, disclosures regarding treatment should be made to others. If the minor's right to confidentiality is merely implied by a legal statute, counselors should seek consultation with a colleague or supervisor, and legal advice may be needed before deciding whether to release information if the minor has refused to sign a confidentiality waiver.

It further appears that in states with Rights of Minors to Treatment acts counselors are not legally bound (possibly even prohibited, depending on the statute) to reveal information regarding treatment for specified illnesses to the family. These acts normally provide that minors may receive certain types of treatment, such as for communicable diseases, without parental consent. For example, minors in Virginia may seek mental health services from licensed practitioners without obtaining parental permisson.

Interesting questions arise as some school board attorneys insist that school counselors get parental permission to have a child in, for example, a substance abuse or child-of-alcoholic group. This position is presumably taken to protect the school from irate parents.

School counselors do not enjoy privileged communication in the majority of states. Sheeley and Herlihy (1987) reported that 20 states offered full or partial protection for counselor-pupil relationships at that time. In most cases, these statutes provide for numerous qualifications to the privilege status.

Parents often bring adolescents for counseling. In view of legal trends recognizing the rights of minors (14 and older) to give autonomous consent, a number of questions arise: Can parents alone authorize the release of confidential information over the minor's objection? If an unwilling minor is coerced into counseling, what legal and ethical implications does this have for any information shared during treatment? If the parents are paying for counseling, does this entitle them to know what goes on in sessions? In other words, are adolescents 14 and over entitled to the same considerations that might apply to a similarly situated adult? When faced with these situations, the counselor should (1) seek consultation from another professional, (2) obtain legal consultation where there are competing interests and there is uncertainty about how to proceed, and (3) keep the client involved and apprised of actions taken or to be taken. (For further discussion of these and other issues, see *Counseling Minor Clients*, by Mark Salo and Stephen Shumate, in ACA's Legal Series.)

The focus of the counselor in releasing information about children (or any other counselee for that matter) should be on empowering (not coercing) the client to share the information themselves where appropriate. A trusting relationship must have developed and the client must be secure that the counselor will be supportive when this information is revealed.

Nondyadic Situations

Typically the counselor-client relationship has been seen as "one on one" and as involving only two persons. This dates to the earliest examples of one attorney, one physician, or one priest dealing with one client, one patient, or one penitent. The increasing utilization of group counseling and team approaches to treatment has brought about fundamental changes in how the therapeutic relationship is conceptualized. Although adding much to the counselor's repertoire, group counseling and multidiscipline team consultation also pose complex confidentiality dilemmas.

Group Counseling

Ethical guidelines for group counselors (Association for Specialists in Group Work, 1989) stress the group leader's duty to educate clients about the meaning and importance of confidentiality, define privacy limits clearly, set a norm of confidentiality, and caution clients about the difficulties associated with enforcing and assuring confidentiality in this setting. Ethical standards stipulate that the significance of confidentiality and its limitations be covered both before and at various times during the group process.

Clients need to understand the ramifications of group participation, including the risks associated with self- disclosure in a nondyadic situation. Although group leaders can assure confidentiality on the part of counselors, they cannot do so on behalf of group members. Counselors who make pledges of client confidentiality in group situations go beyond their professional province and chance establishing unrealistic or false expectations of privacy that may return to haunt them. However, as an added measure, group participants should sign an agreement that they will respect and not disclose others' confidences. There should be a means of dealing with a member who has broken the bond of confidentiality, and participants should be aware of such possible consequences.

Kearney (1984) examined legislative efforts to provide for confidentiality in group psychotherapy. In general, privilege protections do not apply to communications originating in group situations. The District of Columbia Mental Health Information Act of 1978 (cited in Kearney) requires that mental health professionals provide a written statement to group members describing the prohibition against revealing confidential information.

Multidiscipline Team Consultation

It is not uncommon that the contemporary counseling relationship involves multiple professionals due to community agencies, group practice, the multidiscipline team approach, and various treatment arrangements of corporations and health insurers (HMOs, for example). A client may be unclear or confused about what information may be shared with other involved professionals and under what circumstances.

Appelbaum (1984) found that both inpatient and outpatient clients supported a utilitarian position regarding confidentiality and were receptive about counselors releasing information that might help clients, provided the counselors controlled disclosure. Strein and Hershenson (1991) posited that the counselor may assume two postures in sharing information with other multidiscipline team members. The mental health professional first seeing a client could adhere rigidly to the principle of confidentiality and share no information with other professionals or the family. This stance could have a chilling effect upon teamwork and fail to promote good care. At the other end of the spectrum, the professional could view him- or herself as a "corporate practitioner" and elect to exchange information freely with other team members.

Two assumptions that Strein and Hershenson (1991) identified as undergirding the corporate practitioner role were (1) that multidiscipline team members have agreed to follow the most restrictive ethical guidelines applicable to any of the members (rarely done in practice) and (2) that clients have given informed consent to share information with a mental health professional who will later divulge aspects of the client communication to team members. The authors suggested that it may be practical to assume the corporate practitioner role and adopt an intermediate position in which certain information is shared with other team members on a need-to-know basis. Questions that may serve as a guide for the counselor in daily practice are:

- Has the client been fully informed what information might be shared?
- Is the client aware of the purpose of sharing information?
- Has the client consented in writing to this?
- Is the client aware of who will receive this information?

Marriage and Family Counseling

As noted in the Historical Perspective chapter, counselors working with multiple clients simultaneously have limited or no privilege protection in courts of law. The presence of multiple clients usually constitutes an implied waiver of confidentiality and a legal waiver of privileged communication. The *Ethical Standards* (AACD, 1988) do not directly address the issue of

multiclient therapy contexts other than group counseling. The *Code of Ethics for Mental Health Counselors* (1987) offers the following guidance: "In work with families, the rights of each family member should be safeguarded. The provider of service also has the responsibility to discuss the contents of the record with the parent and/or child, as appropriate, and to keep separate those parts which should remain the property of each family member" (AMHCA, 1989, Principle 5.j).

School counselors, who work increasingly with families, have a primary obligation and loyalty to the pupil-counselee, according to the *Ethical Standards for School Counselors* (ASCA, 1984). Separate responsibilities to parents specify that they are informed of the counselor's role and the confidential nature of the counseling relationship (section B).

The American Association for Marriage and Family Therapy *Code of Ethics* (1991) specifies that marriage and family therapists cannot disclose client confidences to anyone except as mandated by law, or to prevent clear and imminent danger to person(s), or when the therapist is a defendant in a civil, criminal, or disciplinary action arising from the therapy, or when the therapist is subject to the terms of a previous written waiver. The AAMFT principles further stipulate that each legally competent family member must waive confidentiality and that without such permission the family therapist is prohibited from disclosing information received from any family member.

Practitioners should help develop, know, and follow policies applicable to their particular settings (Watkins, 1989). Licensed or certified counselors should determine whether they are included in any extant privileged communication laws, if the statute covers marriage and family therapy situations, and what exceptions may exist. As always, it is best to spell out clear expectations and exclusions to confidentiality at the start of treatment. AAMFT ethical principles represent a good general foundation for marital and family counselors. The usual absence of privileged communication protection in court testimony is a confidentiality limitation that clients should be told about at the start of treatment.

Family Consultation

There are occasions when only one member is technically the client. Studies have shown that clients want to be aware of any (specific) information being released to the family. Family counselors often conceptualize problems systematically and are always concerned about family support systems. Therefore, counselors must use good clinical judgment in releasing information to concerned family members and should rely upon generally accepted standards that include:

- discussing with clients what information is to be shared with family members
- obtaining a written client waiver before sharing information
- evaluating the client's mental status to assess competence and to grant consent if there is a specific basis to do so, or making a referral if the counselor lacks evaluation skills
- making a clinical decision about what the family has a need to know
- breaching confidentiality only under compelling circumstances, i.e., dangerousness to others.

Multiculturalism

A recent issue of the *Journal of Counseling and Development* (Pedersen, 1991) was dedicated to multiculturalism, which was described as a fourth force in counseling that acknowledges the complexity of culture. Ibrahim and Arredondo (1990) recommended the expansion of ethical standards to better address cultural factors and demonstrated that concepts such as freedom of choice and self-disclosure have different meanings based upon one's cultural background and ethnicity. They also recommended that counselors refer a client when they have no training and experience with the client's cultural group.

Counselors must acknowledge and remain sensitive to how cultural differences about privacy and disclosure may affect client expectations, interpretations, and understandings regarding confidentiality. A client's cultural make-up necessitates that

counselors pay close attention to insuring that the client knows about confidentiality parameters, that disclosure decisions are informed, and that the client has an opportunity to question or clarify information presented. When the counselor does not demonstrate respect and sensitivity by careful attention to these areas, the possibility for a malpractice suit, civil complaint, or allegation of ethical misconduct may ensue in addition to the damaged therapeutic alliance.

Gerocounseling

Counselors for older persons may experience a number of confidentiality conflicts. Difficulties may arise, for example, when a third party, other than the client, seeks to initiate counseling and when the client shares information regarding physical or emotional abuse. Cavallaro and Ramsey (1988) provided two pointers for gerocounselors, which we have adapted:

1. If hired by an institution, determine who the client is. Some employers believe that paying the counselor's salary entitles them to all information.
2. In general, follow state laws and agency or institutional policies in reporting suspected abuse.

Clients should be told initially about limits of confidentiality. It is advisable when doing so to share the most important information at the beginning or end of the communication if impairment in state of consciousness or memory is present. Fitting (1986) noted that alteration of the older client's decision-making capacity due to medical and health considerations must be considered, although chronic illness does not necessarily impair the elderly client's autonomy to make informed choices. Family consultation is often important in assessment. The counselor should apprise the client prior to making any confidential disclosures to family members.

Many states have passed adult protection laws that require professionals to report suspected abuse or neglect. Should agency policy or direction be contrary to a state law mandating that a report be made, the counselor should discuss the conflict with supervisors and others as appropriate. Counselors who disregard

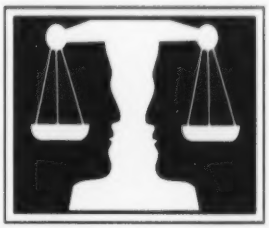
state laws can be held accountable, regardless of institutional policies.

Sex Offender Counseling

Some persons enter treatment voluntarily or by court order because of sexual offenses. In other situations, they may be seeking treatment relative to past or ongoing abuse that has never been reported to child protective services or other legal authority. In some states, the counselor is by statute specifically mandated to report past abuse, even when it is not ongoing. Other states are silent on the topic, so it is best to check state statutes dealing with sex offenders and abuse reporting requirements.

The best solution for the sex offender counselor is to make sure clients are fully aware of confidentiality limitations at the outset of treatment. When faced with the need to make a report of past or current sexual abuse, the counselor should discuss this with the client-perpetrator. Clients may be permitted, according to the counselor's best judgment, to make reports themselves in the counselor's presence.

The primary responsibility of the counselor here is to know the exact language of the state statute and make sure it is followed. There is no set formula for deciding whether abuse might have occurred. However, once a determination has been made that abuse might have occurred, it is necessary to report. Because specific state statutes vary greatly, it is important to be totally familiar with the state laws applicable to the counselor's practice.



Privacy and Record Keeping

What are the ethical and legal standards for confidentiality in record keeping? What happens when a counselor's records are subpoenaed? How can access to counselor records be best controlled? What are the basics for ensuring privacy in record keeping? Answers to each of these important questions are explored in this chapter.

Ethical and Legal Standards

The *Ethical Standards* (AACD, 1988) address the confidentiality of counseling records in several aspects. Section A.6 indicates that information provided to the general public, peers, subordinates, or supervisors by counselors must not identify the client. Further, members must take steps to maintain confidentiality in the storage and disposal of records (section B.2). The *Standards* further stipulate that counseling records, including "interview notes, test data, correspondence, tape recordings, electronic data storage, and other documents," are "professional information" for counseling use and should not be considered part of institutional or agency records unless specified by statute or regulation (section B.5). Release of this information should occur only with express client consent.

The *Standards* (in section B.6) also require the counselor to ensure that data stored in a computer is:

- limited to information that is appropriate and necessary for the services being provided
- destroyed after it is determined that the information is no longer of any value
- restricted in terms of access to appropriate staff members.

Thorough, professional record keeping can be a big help to the counselor in the event of legal action alleging negligence or malfeasance. A client's record has been honored in court as a good representation of what actually occurred.

Where appropriate to the setting, all counselors should maintain appropriate business records containing dates of sessions, fees, and payments received. These records are distinguished from the counselors' clinical case notes detailing assessment information, treatment plans, and progress notes.

The agency for which a counselor works may require extensive case notes in order to ensure protection against possible court action or to meet accreditation, policy, or regulatory requirements. For purposes of these institutional records the client must be informed of what goes in the records, who has access to them, and for what purposes they may be used.

Subpoenas for Records

Many counselors are concerned about client confidentiality upon receipt of a subpoena for records. When the issuer is a client or former client's attorney, confidentiality concerns are eliminated. The client has waived the right to privacy. Even in this instance, however, counselors should evaluate the information in their records to determine if there could be facts that might be harmful to the client's cause. If so, the client and, by client permission, his or her attorney should be notified to discuss the implications of releasing any records. This is not an absolute but is done in fairness to the client because information subpoenaed by one side in a legal dispute is discoverable (available) to the opposing counsel. There are situations in which the client's attorney may withdraw a subpoena after learning about the contents of the materials requested.

The following guidelines extracted from Fisher (1991) and Remley (1991) may help counselors faced with subpoenas for their clinical records provide reasonable privacy protection for clients:

- Determine if current or former clients want the subpoenaed information disclosed. Ensure that they fully understand the potential ramifications of disclosure. If the client is absent or unavailable, it is safest to assume that he or she does not agree to the release unless there is clear evidence to the contrary.
- If the client does not wish information to be released or the counselor believes that disclosure of the counseling record may not be in the client's best interest, obtain permission to speak with his or her attorney about these concerns. The attorney may agree to withdraw his or her own subpoena or file a motion to quash a subpoena issued by opposing legal counsel. Such motions are generally based upon arguments of privilege protection or relevancy to the pending case. Occasionally, a motion to quash may be partially successful, with a judge agreeing to view the information in private (in camera inspection) to determine if the records are admissible.
- If the client's attorney does not behave protectively and concerns still remain, seek legal advice regarding available alternatives appropriate for the specific circumstances.
- Do not simply defy a subpoena without taking definite legal steps through the client's attorney or by securing personal legal counsel.

Some counselors in agency or institutional settings also maintain private or unofficial notes, separate from the official record. This practice is perfectly acceptable. However, the fact that the counselor regards these notes as unofficial and private does not shield them from a subpoena for records, which typically specifies that all documentation relative to a given case be furnished.

Remley (1990) noted that failure to produce all records, if so specified by a subpoena, may subject the counselor to contempt of court charges. Further, the counselor who testifies that all records have been furnished when other unofficial notes have been withheld could be charged with perjury, which is a criminal offense.

Access to Records

An explicit policy should govern security, access, storage, and retrieval of counseling data. Sampson (1990a) provided an ex-

cellent computer-confidentiality case study in which an unauthorized user gained access to password-protected counseling files because the password was taped unobtrusively to the side of the computer. Sampson (1990b) encouraged practitioners to be more assertive and insist on computer software that can be used confidentially. The counselor is ultimately responsible for the management and disposition of all counseling records. Failure to exercise due care in the maintenance of treatment notes can result in a negligence lawsuit and ethical complaints against the counselor.

It is now well established that records may be scrutinized by the client or duly authorized representatives. As noted in the Historical Perspective chapter, privacy acts of the U.S. Congress and the state legislatures have been passed to protect the individual from being harmed by erroneous and defamatory material that may be in various records.

The federal Family Educational Rights and Privacy Act (1974), or Buckley Amendment, discussed earlier in the Client Privacy: Protections and Perils chapter, opened records to the parents of children and gave them the right to challenge the contents thereof. Parents of minor students may inspect such records upon request, and access must be granted within 45 days. Counselors' personal notes on an individual counselee that are not shown to anyone else are excluded from the act. Medical or psychiatric treatment records of a student are not directly accessible but may be examined by an appropriate professional on behalf of the student. In general, custodial and noncustodial parents enjoy the same rights of access to records unless there is a contrary state statute or a court order ending parental rights or otherwise specifically excluding a parent from his or her right to such information.

State freedom of information acts further open to the public records that may contain personal information, such as employment data. Most exclude scholastic and personnel records from scrutiny by the general public while reaffirming the individual's right of access to them. Such records may include various assessments by mental health professionals.

Record Keeping Guidelines

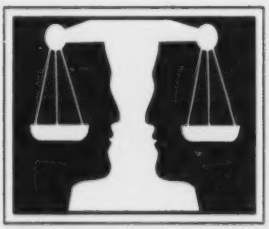
Several authors have reviewed the basics of record keeping and provide general guidance (see Mitchell, 1991; Piazza & Baruth,

1990; Remley, 1990; and Snider, 1987). Key documentation guidelines relating to client privacy that *are* stressed by these writers include the following:

- Avoid leaving files in areas where anyone might gain access to them. Snider (1987) suggested that a locked file cabinet is an absolute minimum storage system.
- Focus upon objective, behavioral statements in writing notes. Label any subjective opinions or conclusions as such in a separate section apart from objective factual information.
- Write any and all case notes as if they may become public information subject to review by the client, the court, or other authorized parties.

In Summary:

- Documentation should be limited to information that is appropriate and necessary for the services being provided.
- Records should be stored securely in a locked area when not in immediate use.
- Access to computerized client records should be restricted to appropriate staff persons who have a need to know this information.
- Clients or their authorized representatives are entitled to inspect records; federal law governs access to school records.
- When clients or their attorney subpoena records, the clients' right to confidentiality is considered waived, and the counselor is obligated to release all of the requested information. Private or unofficial notes must also be furnished when all notes and records are requested.



Counselor Training and Confidentiality

Stadler and Paul (1986) asked counselor educators and administrators to rank order the frequency with which they encountered various ethical dilemmas. Confidentiality was the most common.

Counselor training programs are replete with opportunities for liability exposure. Counseling students are just beginning to learn about their professional responsibilities and to differentiate counseling from social relationships. Students often encounter clients for the first time as they enter practicums. Their mixture of enthusiasm and anxiety increases the possibility for errors and omissions. Students are eager to discuss their experiences during and outside of the class, which sets the stage for possible inadvertent leaks of confidential client information. Or students may forget to execute a confidentiality waiver before releasing information to third parties.

Student errors or omissions can result in liability exposure for the student and vicarious liability for the faculty supervisor (Davenport, 1992; Vandecreek & Harrar, 1988). (See also the forthcoming ACA Legal Series monograph on clinical supervision.) From a legal perspective the student may be sued directly for negligent acts or omissions that harm clients, such as unauthorized privacy breaches. Under the doctrine of contract

law known as respondeat superior (let the master answer), the faculty member assumes vicarious liability for the trainee's negligence. Therefore, either the student or faculty member could be sued if the client or others are damaged in some way as a result of the student counselor's actions or failure to act. For these reasons professional liability insurance for students and faculty in counselor education programs is strongly recommended.

Further liability exposure occurs when counselor education programs require or encourage students to be clients in training practicums (Patrick, 1989). Additionally, some institutions compel students to participate in personal counseling. When counselor candidates serve as practicum clients, the supervising faculty member establishes an indirect dual relationship with the counselor-client in directing the treatment. When faculty serve as counselors and also have administrative, evaluative, or supervisory relationships with students, a direct dual relationship exists. Through direct or indirect dual relationships the faculty supervisor is in a position to learn confidential information about the student-client whom they may also evaluate or supervise.

Kitchener and Harding (1990) discussed the conflicts associated with the supervisor-counselor and client-supervisee combination. A supervisor has dual responsibilities to the supervisee, the work setting, and the supervisee's client. Confidentiality is not necessarily accorded the supervisory relationship. The counselor role, by contrast, requires that the primary obligation is to the client, to whom a duty of confidentiality is owed. What happens if the supervisor's clinical assessment of the student-client suggests psychological adjustment problems that may detract from or impair the student's counseling role?

Counselor trainees should be fully informed of confidentiality limitations in advance of consenting to participate as a client. Strict guidelines are needed to protect the privacy of counselor trainees who serve as clients. Faculty members owe student-clients a duty of confidentiality. If the student's privacy rights are breached, the faculty member may be sued for malpractice or face ethical complaints.

Prospective counselors also need to understand their duty to act when they witness ethical violations. The *Ethical Standards*

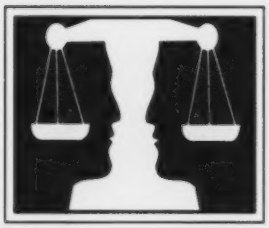
(AACD, 1988) require members to take action to rectify ethical violations (section A.3). Remley (1992) asserted that counselors' demands for public recognition as professionals result in a corresponding responsibility to understand ethical codes and confront others about violations. He also encouraged careful consideration and consultation before initiating an ethics complaint.

A report of the Ethics Committee (AACD, 1991) for 1989–1991 indicated that only five complaints were received each year. (Another 19 were made but did not proceed through the complete review process for various reasons.) This is contrasted to over 15 times that number handled by the American Psychological Association's Ethics Committee. Only one complaint alleging a violation of confidentiality was received by the Ethics Committee in the 2-year reporting period. These data raise a number of questions: Are confidentiality lapses that occur being handled informally, by state ACA associations, or by licensure boards? Are counselors being adequately educated about ethical behavior, including their duty to take action when violations are observed? Are counselors not confronting colleagues because they fear reprisal or wish to avoid conflict that could "rock the boat"?

As the Ethics Committee report notes, it will be of interest to observe whether the number of complaints will rise in proportion to increasing numbers of licensed counselors in the mental health marketplace. ACA's introduction of a professional membership (on July 1, 1992) is likely to increase the value of professional affiliation, and members may be inclined to challenge ethical complaints more vigorously.

Counselor education training programs are rife with opportunities to influence the future ethical behavior of counselors. Positive modeling, having clear policies regarding confidentiality for students as well as clients, establishing clear guidelines for audio- and videotaping of counseling sessions that are monitored and followed up, processing confidentiality dilemmas as they arise, and cautioning enthusiastic novices about discussing cases outside of the practicum setting (except with consultants and supervisors) all may have their impact upon the developing counselor. Counselor supervisors at all levels can also encourage ethical behavior through modeling, monitoring, evaluation, and education with supervisees as dictated by clinical situations that

arise. Counseling students should purchase student liability insurance for their personal protection.



Frequently Asked Questions

Q. One spouse who was seen in conjoint marital counseling subsequently initiates divorce proceedings and requests counseling records. The other spouse does not consent to the release. Should the records for such a conjoint counseling case be released to one spouse without the consent of the other party?

A. The therapeutic contract was for couples counseling. The couple was the client, and the counselor has an equal duty to protect the privacy of both parties. Absent a waiver by both clients or a court order, the counselor should decline to release information under these circumstances. The counselor may need legal advice upon receipt of a court order or subpoena. Generally, privileged communication, if this protection is provided by applicable state statute, extends only to individuals. The privacy of the spouse who does not want the records revealed may be protected by a judge's in camera inspection or other techniques that necessitate legal assistance.

Q. A 14-year-old adolescent being seen for individual counseling divulges during a session the use of marijuana (cannabis) several times weekly, mostly on weekends. Should the counselor inform the parents?

A. The laws, policies, and regulations in the counselor's state and setting determine the appropriate response. If state law

considers minors competent to consent at this age or to otherwise have a statutory right to treatment without parental permission, the counselor should follow the same guidelines as he or she might for a similarly situated adult client. Some agencies and institutions have specific policies governing the confidentiality with minors that will provide further guidance to the counselor. If further evaluation indicates an immediate danger or if the client signs a waiver authorizing the counselor to inform his or her parents, the counselor may contact them. As with all substance abuse, the counselor should be attentive to addressing issues of minimization and denial in the treatment plan and encourage the adolescent to disclose the problem for therapeutic reasons.

Q. An employee assistance program (EAP) counselor refers an adult client for evaluation who is suspected of being alcohol dependent. The employer is concerned because the employee's regular job entails operating heavy equipment under minimal or no supervision. Evaluation determines that a serious alcohol dependence problem exists. Is the counselor obligated to report these findings to the employer?

A. It is important to be clear about one's role and how any information gathered will be handled. The counselor's findings and recommendations should be summarized for the client. The counselor has a duty to warn the employer because of the risk of danger associated with operating heavy equipment while intoxicated, and this should be explained to the client. The employee may elect to enter an appropriate alcohol treatment program. In this case the counselor should request that the client sign a waiver to facilitate notification of the employee assistance referrer. Because the client could withdraw prematurely from treatment, the EAP counselor and the client should be advised of the safety risk arising from failure to follow treatment recommendations.

Q. A college student living at home with parents seeks counseling because of adjustment problems at college. The referral is initiated by the college dean's office be-

cause the student is on academic probation. During counseling, the client reveals having tested HIV positive and engaging in unprotected sex with other college students. How should the counselor proceed?

A. The counselor should inquire about the medical evidence for HIV infection and ascertain whether the client is currently symptomatic. The counselor should advise the client, if an awareness seems lacking, about the contagious and fatal nature of the disease. If the student refuses to agree to having protected sex and declines to notify past sexual partners, the counselor should request the student's permission to contact his or her physician. If permission is granted, the counselor should contact the physician and request assistance in modifying the client's behavior. The client should be referred to his or her physician and an AIDS support group, if available. The counselor should document these steps. Consultation should be sought from two colleagues knowledgeable about professional ethics regarding what actions to take, and these contacts should be recorded. If the client's behavior cannot be modified by the forgoing means, the client should be told that notification will be made to public health officials. If the client does not relent, notification should be made and documented.

Q. A counselor is supervising a counselor license candidate who also works as a social worker. The supervisee is seeing a client from the social work caseload who is placed with a foster parent. The supervisor discovers that the foster mother is the counselor's mother-in-law. What should the supervisor do?

A. The counselor has compromised client confidentiality and therapeutic neutrality by entering into dual relationships. First, the supervisee has responsibility and authority for the child's placement and as such is functioning concurrently in the roles of counselor and social worker. Secondly, the placement of the client with a close relative further creates conflicting duties, jeopardizes confidentiality, and mitigates against the establishment of therapeutic rapport. The supervisor should insist that the counseling relationship be terminated and refer the

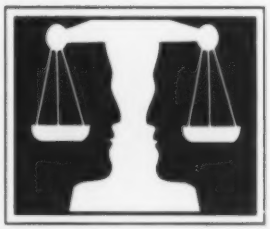
child (with explanation) to another counselor. The ethical issues and violations involved should be discussed with the student, and closer supervision should be arranged.

Q. A 15-year-old girl seeks counseling as she is struggling with a wish for, and fear of, an abortion. She tells her counselor during the first session that under no circumstances can her parents know that she has discussed abortion. What should the counselor consider?

A. Additional information is needed. What is the home situation? Is she really pregnant? Has she seen a physician, and if so, what are the results of that visit? Does the applicable state statute give the minor client a right to counseling about abortion without parental consent? In addition to the legal aspects and issues of confidentiality, the counselor should ask him- or herself, Will my personal values enter into this counseling relationship? Further, if the counselor is employed by an institution, the counselor should inquire whether there is any policy that will guide ethical decision making.

Q. A school counselor commences counseling with a teacher-referred student. Now the teacher would like to know "everything" that was said in the sessions and insists that this is her right as she made the referral. The principal also wants a complete report on this student because the student is "known as a trouble maker." How should the counselor respond to the teacher and the principal?

A. The counselor must explain to the teacher and principal that what is said within the counseling relationship is generally confidential. Both the teacher and principal should have had this thoroughly explained before an incident such as this arose. With client permission the counselor may share with the teacher those elements gleaned that bear on educational matters. If issues such as child abuse, threatened suicide, or the sale of illegal drugs on school grounds were discussed in counseling, the counselor may be obliged to share more with the principal as the supervisor. The counselor has a duty to let other professionals within the school know his or her responsibility to keep what is learned in counseling sessions confidential.



Guidelines for Practice

When commencing a therapeutic relationship with a client, consider confidentiality and privileged communication issues and . . .

1. Review major exceptions to confidentiality such as child abuse, court order, threat of harm to self or others, and briefly review policy guidelines for releasing information. This information may be covered in a professional disclosure statement given to clients.
2. Indicate to the client whether counselor-client communication is protected by state privilege statute and, if so, what is and is not covered.
3. For clients who plan to utilize insurance billing, include in the intake agreement or other disclosure a disclaimer of responsibility for information once it leaves the counselor's office.
4. For clients seeking treatment pursuant to court order or otherwise involved in a civil or criminal legal action during which counseling information may be requested, discuss how confidentiality will be handled, including special exceptions that may apply pursuant to court order or subpoena.
5. Re-review any relevant aspects of the therapeutic relationship as indicated, particularly if the client's situation has or may change, i.e., through impending divorce.

If a client requests the release of confidential information . . .

1. Clarify the information with the client before sending it if the client's authorization is not clear regarding what information should be disclosed or to whom.
2. Discuss any implications the release may have with the client if you have not already done so. Point out any negative consequences that might result from disclosure if the client does not mention or seem aware of these.
3. Retain a copy of the release authorization, and note the date that the records, or portions thereof, were released.

If a spouse, parent, or other concerned person calls or writes to request information regarding the client's treatment . .

1. For clients ages 18 and older, if there is no client waiver to disclose information to the inquiring party, explain the limitations of confidentiality and indicate that such private communications cannot be shared, that even acknowledgement of whether the client is in counseling or attending sessions represents a disclosure. Follow applicable ethical standards and institutional policies if you are a counselor in a school or agency setting.
2. Find out about the specific provisions of your state laws governing the treatment of minors. Some states recognize minors' rights to seek counseling without parental consent, sometimes for specific situations such as substance abuse or abortion. These statutes, where they exist, may or may not stipulate that information arising during counseling is confidential. Some states also now recognize the right of minors, usually ages 14 and older, to object to psychiatric hospitalization against their will. When statutes recognize minors' capacity to grant or withhold consent for treatment, a corollary question is raised about whether the minor may also control the release of confidential information. This represents a gray area requiring consultation, clinical judgment, and perhaps legal advice. As noted in the discussion regarding minors in the Special Considerations chapter, school counselors may operate under policy constraints that may be based upon a legal interpretation of state laws by individual school board attorneys.

3. For clients under the age of 14, discuss as appropriate general information with parents, saying, for example, "We are working on anger and self-esteem issues and things are progressing well." Discuss inquiries from nonparent parties with the child-client and parent before releasing any information, and execute a waiver signed at least by the parent before any disclosure. Some counselors also prefer to have the minor sign, although this is not usually required unless stipulated by a written policy or legal statute.
4. Apprise the client (and parent for minors) of requests for information. Noncustodial parents usually have a right to their child's medical information (mental health records are included) unless a court has terminated their parental rights or otherwise restricted access to information regarding the child. They may be asked to follow customary procedures, such as signing waivers, to obtain information and records.

If your client proposes to tell you a "secret" on the condition of absolute confidentiality . . .

1. Empathize with the client's fear or apprehension but remind him or her that there are limits about what can be kept private.
2. Reassure the client and offer support.
3. Explore the client's feelings and inhibitions about disclosure generally, but avoid pressuring a client to divulge such confidences.

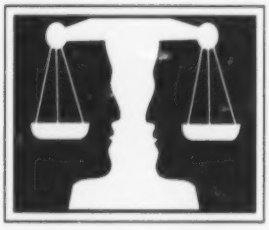
If a counselor is treating a court-referred or court-involved client . . .

1. Obtain a copy of any court order to determine what treatment requirements have been imposed for provider and client.
2. Review confidentiality limitations with the client.
3. If written progress reports or evaluations are required, apprise the client what types of information will be reported to the court. If appropriate to the client's situation and not prohibited by policy or court order, review written reports with the client before they are sent.
4. Define roles clearly for probation officers, social workers, and others involved in the case, and discuss in advance with the

client guidelines about case coordination and release of information.

When a counselor has multiple clients, for example, in group, family, or marriage counseling . . .

1. Ascertain what laws, policies, and regulations apply to these situations. Some states offer qualified privilege protection for communication originating under such circumstances.
2. Discuss confidentiality guidelines at the inception of treatment. For group counseling, indicate that confidentiality is expected, and add a disclaimer that confidentiality by others in the group cannot be assured. For family counseling, inform clients about applicable policy, for example, that information is only disclosed with the consent of all members except in cases of child abuse or neglect.
3. If a client breaches another's confidence, follow this up and take appropriate steps to prevent further occurrences.



Summary

A general ethical rule is that all communications with clients should be kept in confidence. Legal tradition and mental health professional codes of ethics mandate this conduct by counselors. Studies have indicated clearly that clients have an expectation of confidentiality and prefer to be told in advance about any limitations that apply. Professional disclosure statements outlining the parameters of confidentiality are becoming the standard of care among mental health practitioners and their credentialing bodies.

Current privileged communication laws are generally limited in scope and provide only a partial protective shield for communications arising in the counseling relationship. The absence of a privilege statute does not in any way diminish the counselor's ethical duty to maintain client confidences. Attaining meaningful privileged communication statutes for therapeutic relationships should assume, alongside licensure, a high priority among professional organizations.

Privacy belongs to clients and can be waived. In general, the right of minors to privacy belongs to their parents or guardians. There is a trend toward granting minors greater rights to self-determination and privacy, and some state statutes already do so with various qualifications.

Counselors should make reasonable efforts to discuss with clients the implications of releasing confidential material such that any consent for disclosure is informed. Once clients duly authorize the release of confidential information, counselors should cooperate and disclose it.

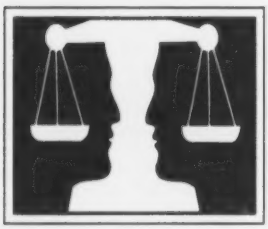
There are many exceptions to confidentiality, all of which pose potential problems for counselors. These include client dangerousness to self or others; court orders requesting information; the presence of third parties during a counseling session, which constitutes an implied waiver of confidentiality; child abuse or neglect where the client is the victim or perpetrator; counselor communication with parents or guardians regarding the treatment of minors; and the counselor's right to obtain legal and clinical consultation. Each exception requires clinical judgment, and there are no absolute guidelines to ensure that a particular decision is correct. In the event a client's privacy rights are compromised inappropriately, counselors can be sued for malpractice (negligence). This is one reason that professional liability insurance is so critical.

The counselor's work setting may influence ethical choices regarding confidentiality. Counselors in educational settings should be aware of the Buckley Amendment (Family Educational Rights and Privacy Act, 1974) and its provisions governing the release of confidential information about students. Military mental health professionals may struggle with a dual duty to the client and those in command authority, a potential threat to client confidentiality. Federal regulations govern confidentiality in alcohol and other drug abuse treatment facilities receiving federal funds. Public offender counselors who work in correctional settings may find confidentiality boundaries more permeable for incarcerated clients because of state statutes regulating information about prisoners. Some counselor educators function in dual roles with students that may compromise privacy when the student is also a client. Additionally, faculty members teaching practicums must act to prevent eager trainees from discussing cases.

Regardless of the counselor's work setting or population served, the need for documentation is usually present. The counselor must ensure that access to confidential records is limited to persons with a legitimate need to know this information. As computerized information systems become virtually universal

and more complex, greater care has to be exercised in this electronic filing of information. Anything included in confidential counseling records may be subject to court subpoena or release to the client who signs a confidentiality waiver.

Courts of law are tending to give greater protection and larger settlements to consumers. Counselors need increased amounts of professional liability insurance and a better understanding of legal and ethical issues in the future.



Discussion Questions

1. A high school counselor's client discloses being involved in criminal activity. The counselor had assured the client that everything said in a session was confidential. Should the counselor have alerted the client to the possibility that certain circumstances might warrant a breach of confidentiality? Must the counselor break confidentiality in this instance? What should be the determining factors in the counselor's decision about whether to breach confidentiality?

2. A counselor in private practice has been seeing a single adult for treatment of depression with suicidal ideation. While on a close monitoring status with a suicide contract in effect, the client fails a scheduled appointment without notice. The counselor's attempts to reach the client at home or at work are unsuccessful. How should the counselor proceed? Should the counselor breach confidentiality and notify a family member or civil authorities about the client's condition under the duty to warn exception? Should the counselor seek a civil mental detention order to have the client picked up and brought to a hospital for further evaluation?

3. A faculty member is approached by a student serving as a client in an introductory counseling practicum who is upset that the student-counselor's roommate, a friend of the student-client, has divulged information that the client disclosed

in a counseling session. This situation has strained the client-roommate social relationship. Investigation reveals that the student-counselor played a videotape of a counseling session in the presence of the roommate. What steps should the faculty member take to resolve this situation and prevent future occurrences? Was the student negligent? Is the faculty supervisor liable for the student-counselor's actions either vicariously or directly?

4. Peer counselors/helpers are used by the school counseling department. Several students have been known to "slip" and divulge information that is considered confidential. What is the counselor's liability for the peer counselors' actions? Does the counselor have the same responsibility if a graduate student intern were involved rather than the peer counselor? What can the counselor do in the future to prevent this?

5. A counselor in a community mental health agency receives a phone call from the vice-principal of a local high school where a 17-year-old adolescent client is enrolled. The youth reported leaving school early one afternoon for a therapy appointment, and the school administrator is seeking confirmation about the validity of the student's excuse, which the counselor immediately recognizes was a fabrication by the client. Is this information confidential, and should the counselor disclose what is known? Did the client's disclosure to school officials about being in therapy constitute a waiver of confidentiality? What is the agency's policy regulating the release of information regarding minors? Is there a state statute regarding the treatment of minors relevant to this situation? Should the counselor notify the parent or guardian about the call from the school system? Is professional consultation indicated?

6. An inpatient substance abuse counselor who conducts group sessions learns that a client's co-worker, also a program participant, has leaked confidential information about the client's substance abuse to two of their joint friends. What actions should the counselor take? Is the counselor liable for this unauthorized disclosure? What confidentiality expectations and disclaimers did the counselor discuss when the

group sessions began?

7. A counselor license candidate reports casually to his clinical supervisor that an adult client's ex-spouse was given details regarding the client's treatment progress during a telephone conversation. The supervisor learns that the client did not authorize the disclosure. Do the supervisee's revelations to the ex-spouse represent a breach of ethical standards? Does this release constitute actionable negligence by the license candidate? Is the supervisor liable in the event of a malpractice suit? What should the client be told? Is there a need to obtain legal advice or other professional consultation in this situation?

8. A 13-year-old inpatient psychiatric client told her counselor about incidents of purported physical abuse by her stepfather immediately prior to a planned family therapy session at the hospital. In doing so, the client pleads with the counselor not to mention this to her stepfather or mother. Should the counselor confront the stepfather with this information contrary to the minor's wishes? Is the counselor obligated to report such an incident to child protective services? What is the state law about reporting abuse? What is the hospital's policy under these circumstances? Should the counselor discuss the information with the client's attending physician? What may the counselor disclose in a treatment team meeting regarding the client?

9. Is client privacy violated by sending bills and other correspondence using letterhead business versus plain envelopes? Is this practice unethical, quasi ethical, or a nonissue? Are there any legal considerations?

10. An agency counselor practices in an office where the walls are not sound proofed. A client reports that counseling sessions can be overheard from the waiting area. What should the counselor do? Is either the counselor or the agency liable for information inadvertently overheard by others? Until the situation can be corrected, should the counselor advise clients about the problem? If the counselor reports the situation to

his or her supervisor and there is no indication of corrective action, what steps should be taken?

Suggested Readings

Cohen, E. D. (1990). Confidentiality, counseling, and clients who have AIDS: Ethical foundations of a model rule. *Journal of Counseling and Development, 68*(3), 282–286. Provides a good model for making decisions about AIDS-related confidentiality decisions.

Hendrix, D. H. (1991). Ethics and intrafamily confidentiality with children. *Journal of Mental Health Counseling, 13*(3), 323–333. An excellent overview article regarding confidentiality with children.

Herlihy, B., & Golden, L. B. (Eds.). (1990). *Ethical standards casebook.* Alexandria, VA: *American Association for Counseling Development.* A good practical reference regarding ethical issues. The casebook contains copies of ethical standards, illustrations of acceptable and unacceptable ethical conduct, case studies, and essays on important ethical practice topics including confidentiality.

Remley, T. P., Jr. (1991). *Preparing for court appearances.* AACD Legal Series, Vol. 1. Alexandria, VA: *American Association for Counseling and Development.* Includes practice guidelines, how to handle subpoenas, and appropriate witness behavior. Several chapters address privacy-related issues.

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NOTES

"I applaud (Series Editor) Dr. Remley and (ACA) as well for the idea of a series of monographs in dealing with legal issues that will help mental health professionals and counseling students."

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